



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WEST HOUSTON MEDICAL CENTER
c/o HOLLOWAY & GUMBERT
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098-3926

Carrier's Austin Representative Box

19

MFDR Date Received

JANUARY 11, 2007

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-07-3072-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated January 10, 2007: "Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%...Therefore, the fees paid by The Hartfordxchange Center do not conform to the reimbursement section of Rule 134.401."

Requestor's Position Summary Dated February 5, 2007: "Pursuant to DWC Rule 133.307(g)(3), please find enclosed the affidavit concerning cost and necessity of services of Vanessa East and medical records that are relevant to the medical care and treatment provided to [Claimant] at West Houston Medical Center, which was inadvertently omitted from the documentation submitted in our original request for MDR packet dated January 10, 2007."

Affidavit from Vanessa Wast dated January 10, 2007: "The services provided were necessary for the treatment of a workplace injury and the amounts charged for the goods and services provided to [Claimant], as reflected on the attached records, were the usual and customary charges of West Houston Medical Center the time and place that the services were provided."

Amount in Dispute: \$19,482.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 26, 2007: "It is the carrier's position they have correctly reimbursed the provider using the per diem methodology and no additional reimbursement should be made."

Response Submitted by: The Hartford

Respondent's Position Summary Dated March 15, 2007: "Please be advised that the carrier does not have any additional documentation to submit at this time."

Response Submitted by: The Hartford

Respondent's Supplemental Position Summary Dated September 12, 2011: "Respondent submits this Respondent's Post-Appeal Supplemental Response as a response to and incorporation of the Third Court of Appeals Mandate in Cause No. 03-07-00682-CV...Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception. The Division must conclude that payment should be awarded in accordance with the general *per diem* payment in accordance with 28 Texas Administrative Code §134.401 (repealed)..."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
January 12, 2006 through January 20, 2006	Inpatient Hospital Services	\$19,482.21	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- W1-workers comp state fee sched adjust. submitted services were repriced in accordance with state per diem guidelines.
- W1-WC State fee sched adjust, submitted services are considered inclusive under the state per diem guidelines.
- 16-Claim/srvic lack info which is needed for adjudication. In order to review this charge we need a copy of the invoice detailing the cost to the provider.
- W1-Workers compensation state fee schedule adjustment, when medically necessary, implantables & orthotics and prosthetics are reimbursed at cost to the hospital plus 10% per the Texas Acute Care Inpatient Hospital Fee Guideline.
- 45-Charges exceed your contracted/legislated fee arrangement. The charges have been priced in accordance to your fee for service contract with First Health.

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges Exceed Your Contracted/Legislated Fee Arrangement." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines
2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 820.09.
3. The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 TAC §134.401(c)(6). The requestor asserts in the position

statement that “Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor (‘SLRF’) of 75%.” Division rule at 28 TAC §134.401(c)(6), effective August 1, 1997, 22 TexReg 6264, states, in part, that “The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate.” As stated above, the Division has found that the primary diagnosis is a code specified in Division rule at 28 TAC §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1.

5. Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission.”
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
 - The requestor’s position statement asserts that “Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor (‘SLRF’) of 75%.”
 - The requestor does not discuss or explain how additional payment of \$19,482.21 would result in a fair and reasonable reimbursement.
 - The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per Division rule at 28 TAC §134.401(c)(6).
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
 - The Division has previously found that a reimbursement methodology based upon payment of a hospital’s billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”
 - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
 - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	_____	1/31/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.